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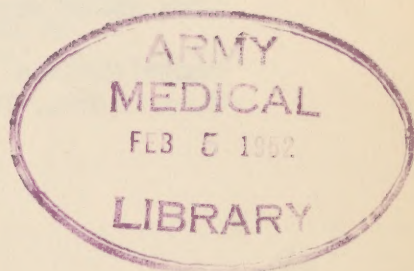
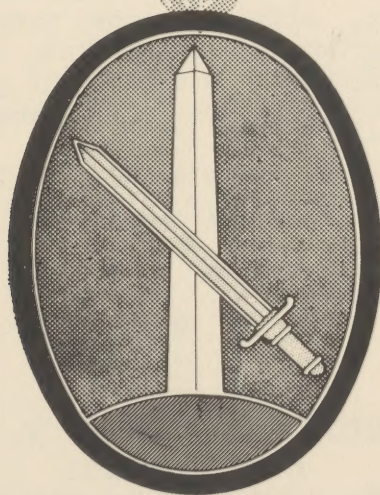
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MONTHLY HEALTH REPORT

Military District of Washington



RESTRICTED
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DECEMBER 1951



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This "Monthly Health Bulletin" invites every reader to participate in its preparation by contributing articles. There must be something in the daily military experiences that will interest others and possibly be helpful to others. Administrative directives, professional articles, clinical notes, descriptions of new devices and instruments are welcomed. While the number of copies of this publication is not great, there is a wide distribution, geographically speaking.

Contributions should be addressed to The Surgeon, MDW, Room 2D-201, The Pentagon, Washington 25, D. C.



MAJOR GENERAL THOMAS W. HERREN
COMMANDING
MILITARY DISTRICT OF WASHINGTON
Room 1543, Building T-7, Gravelly Point
Washington 25, D. C.



INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

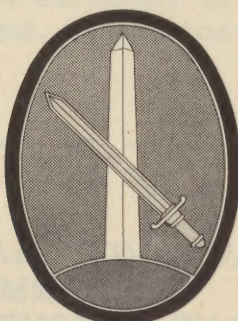
It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions; as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

ROBERT E. BITNER
Colonel, MC
Surgeon

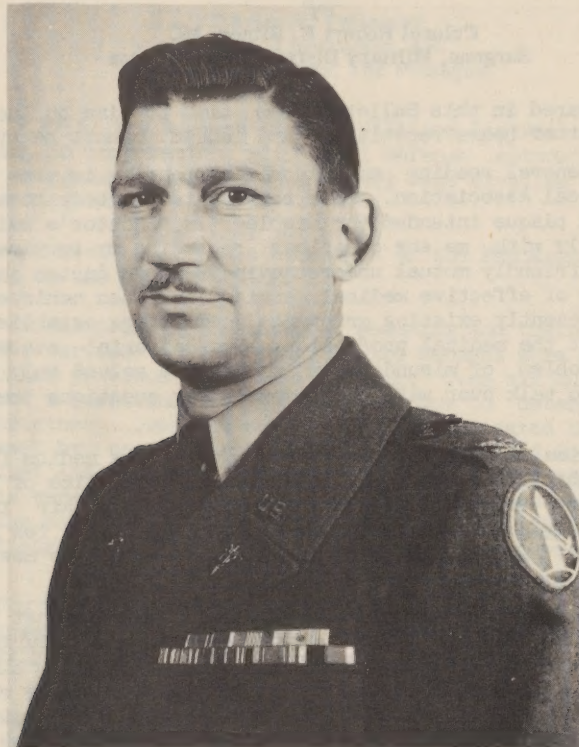
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MDW MEDICAL SERVICE PERSONALITIES

COLONEL OSCAR J. OGREN, DENTAL SURGEON



Colonel Oscar J. Ogren, Dental Corps, Post Dental Surgeon, Fort Belvoir, Virginia and Dental Surgeon, Military District of Washington, is a native of Britton, South Dakota. His early education was received in the public schools of Minneapolis, Minnesota, where his family moved during his childhood. He is a graduate of the University of Minnesota, College of Dentistry, receiving the degree of DDS in 1932. He was a member of the ROTC while in college, and was commissioned 1st Lieutenant, Dental Corps Reserve, upon graduation.

He accepted an Army Internship in 1932, and was assigned to Fort Jay, Governors' Island, New York. Upon completion of this internship, he entered the private practice of dentistry in Minneapolis until his recall to active duty in 1934. He transferred to the regular army in 1935.

Colonel Ogren married Miss Gertrude S. Weart of Fort Leavenworth, Kansas in 1938. They have three children; Charles D., age 10, John W., age 3, and Gertrude W., age 1 year.

Colonel Ogren has served at many posts in this country and abroad during his career. His early assignments included Fitzsimons General Hospital, Presidio of San Francisco, Fort Leavenworth, and Forts Davis and Clayton in the Panama Canal Zone. He also had a previous tour of duty in the Washington area as Post Dental Surgeon of Fort Myer during 1941-42.

His World War II assignments included duty as Chief of Dental Service of the 124th General Hospital, Dental Coordinator of the 803rd Hospital Center, and Assistant to the Theater Dental Surgeon, Surgeon General's Office, ETOUSA.

More recently, he has been Assistant and Acting Chief of Dental Service at Walter Reed Army Hospital and Instructor at the Army Dental School, prior to his present assignment.

His awards and decorations include the Bronze Star Medal, Commendation Ribbon, American Defense Service Medal and several others.

ADMINISTRATIVE SERVICE

DOCTOR - PATIENT RELATIONSHIP

By

Colonel Robert E. Bitner, MC
Surgeon, Military District of Washington

Articles have appeared in this Bulletin from time to time on the subject of the Doctor-Patient Relationship. The matter bears repetition, and indeed, cannot be overemphasized.

We recommend for general reading an editorial appearing in the November 10 issue of the Journal of the American Medical Association. This representative body considers the matter so important that it has devised a plaque intended for display in a doctor's waiting room. It reads: "I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly mutual understanding between doctor and patient." This mutual understanding is the keynote of effective medical service, and when achieved, will obviate the unpleasant necessity of the presently existing grievance committees established by medical societies to hear the complaints against the medical profession. The editorial states "It has become obvious that the public relations problem of misunderstanding can be solved only in the doctor's office. Patients must be encouraged to talk over with their doctor any questions they may have regarding his services or his fees."

On the part of service personnel, there has always been a medium for expressing grievances of all sorts. Free use of this medium has been made through the Office of the Inspector General at the various staff levels. Some impetuous or ill-advised individuals air their complaints directly to a Congressman without seeking redress through the appropriate IG. A few have even written to the President. In unusually urgent cases, this may be excusable, but for the most part, such action adds to the time required to solve the difficulty.

All service personnel should feel free to air grievances against the Medical Service, and opportunity to do so should be afforded locally. This infers that the Surgeon of the installation is personally interested in the matter. Either he or a person designated by him should sympathetically and intelligently listen to the grievance, investigate, and make a suitable reply to the complainant. Many grievances are the result of misunderstanding, as pointed out in the editorial. Probably 95 per cent of all complaints could be satisfactorily answered locally within the Medical Service itself, if the intense interest of the Medical Service in the problems of patients received sufficient publicity. It is in the interest of the local commander and the local surgeon to foster and encourage publicity of this nature.

Education of medical service personnel is of equal importance. Every officer, every enlisted man and woman, and all civilians connected with the Medical Service must be imbued with the idea that their principal function is to render courteous, efficient service to the patient. How can this be done? Only through constant education by means of Staff Meetings, bulletins, and personal interviews with our subordinates. An opportunity exists to emphasize this in our training programs.

Doctor-Patient relationship in the Army means even more than the same relationship in civilian life. This occurs because of our organization in which a number of persons are engaged in the handling of even one patient. Each person handling the case must be an emissary of good will for the Medical Service. One individual can easily undo the good effect produced by the efforts of many other if that person is not personally convinced of the importance of his job. All members of the Medical Service must be constantly aware that helpfulness, above all, must be their guiding motivation.

Let us sell the Medical Service to those persons whom we serve!

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MEDICAL OFFICER'S PROFESSIONAL TRAINING RECORD

Action by individual.---DD Form 408 is furnished as a convenience to medical officers. It is the responsibility of each individual officer personally to maintain his professional training record in a manner that will be acceptable to his particular specialty board. The individual may forward the record to the specialty board at any time for evaluation. The record will not be forwarded through the Office of The Surgeon General but will be forwarded direct to the board concerned. Ordinarily, the applicant will retain this record until he makes formal application to the board. Direct correspondence with the boards relative to this matter is hereby authorized.

(The above is from C-1, SR 40-10-45, dated 21 September 1951)

ADMINISTRATIVE SERVICE

THE PENTAGON PREPARES

By
Charles V. Feichtner
First Aid Instructor, ARC
AGO, Dept of Army, The Pentagon

In the Spring of 1951, the Surgeon of the Military District of Washington instituted a First Aid Training Program, in cooperation with Civil Defense authorities, to provide adequately trained personnel for the emergency treatment of military and civilian personnel in the Pentagon in the event of a large scale disaster.

The plan was placed ineffect for the occupants of the Pentagon, and other building commandants have based their plans on the Pentagon plan.

The first phase of the program consisted of securing and training a suitable number of instructors in First Aid. The services of the Pentagon Fire Wardens were utilized to make a survey of the Pentagon personnel who had previous First Aid Training. Over six hundred persons indicated that they had such training, and a questionnaire was sent to them to determine their availability for training as First Aid Instructors. Over one hundred persons indicated their availability, and these persons were then interviewed by representatives of The American Red Cross to determine their aptitude as instructors for First Aid classes. Fifty persons were finally selected to receive instructor training. These individuals were selected primarily because of prior experience in teaching or supervisory work, since it was the experience learned during World War II that better results are produced by training a teacher to instruct in First Aid than by training a First Aider to become a teacher.

The group of fifty was then given a series of instruction courses embracing the Standard and Advanced First Aid Courses, Instructor training, and training in the Civil Defense Supplement to the Red Cross First Aid Textbook.

The intent of the above training was to produce a group of instructors to act as the instructor group in teaching the Standard First Aid course and Civil Defense Supplement to approximately ten per cent of the occupants of The Pentagon. The training of the instructor group was given during normal working hours.

Arrangements are now being made to permit the second phase of the program, which involves the instruction of approximately ten per cent of the occupants of the Pentagon, to be taught during normal working hours also.

Concurrent with training, eight rooms in the Pentagon have been designated as storage spaces for first aid supplies for emergency use. These rooms were designated on the recommendation of Pentagon engineers that these rooms were structurally "safer" than other rooms in the Pentagon. In each of these rooms certain non-critical first aid supplies will be stockpiled. These supplies will be the responsibility of and will be under the supervision of a first aid instructor who will inventory and inspect the supplies periodically. In the event of an emergency, these eight rooms will be manned by assigned first aid instructors assisted by other assigned personnel in the Pentagon who have completed First Aid Training. It is anticipated that these first aiders will be given special practice in the form of "dry runs" from time to time in different phases of first aid activities and functions.

In addition to the eight storage rooms, the five emergency rooms and/or Dispensaries operated by Medical Department of the Army and the Civilian Employee Health Service Program in the Pentagon will also be used to store first aid supplies, so that a total of the thirteen areas, covering all portions of the Pentagon, will be available for emergency use in the event of a large scale disaster involving the Pentagon.

It is felt that a program similar to the above should be instituted for any large concentration of persons in Government or private industry to provide adequate number of individuals qualified to administer emergency first aid.

ADMINISTRATIVE SERVICE

OUR EDUCATIONAL PROGRAM FOR CORPSMAN

By
1st Lt Marie V. Hontz, ANC
US Army Hospital, Fort Belvoir Virginia

These changing times, the expanding defense program and the rapid turn-over of personnel has brought forcibly to our attention the necessity for an extensive and intensive educational program for medical technicians.

At the present time only a handful of men previously instructed in classes at Fort Belvoir Army Hospital remain on duty. A shortage of nurses at the hospital has also increased our demand for trained medical technicians. Adequate nursing care for our patients must be provided: therefore, it is necessary to train enlisted personnel to aid in meeting these nursing needs, guidance and supervision of the professional nurse. Good interpersonal relationships are fundamental to a successful training program. A sympathetic understanding of the importance of their contribution as members of a unified health team in giving care and treatment to patients of the role they play in the prevention of diseases is required by all personnel.

A variety of skills is required in the care of patients. In developing those skills, the technician must understand patient behavior so he can assist that patient in making a satisfactory adjustment to his injury or illness. In developing good relationships with patients, the technician must learn something about sound health practices and how he himself reacts to difficult situations. Frequently a patient assumes a defensive attitude. His mind may be bristling with questions, possessed with undefined and subtle fears. Everything is strange and unknown, instinctively he dreads the mysterious and the unfamiliar. Much can be done to allay that patient's fear and to aid him in finding himself in his new environment, or in his contacts with the ward-officer, and with the various examinations and treatments which may be necessary.

A guide outline for the program has been developed to include situations which indicate the range of knowledge and skills that the hospital technician should require in order to perform his duties effectively. Careful consideration of the needs and capacities of the learned has been foremost in our minds. Distribution of the learning load has been our aim, and over-loading or too little learning activity has been avoided so that the interest of the trainee may be maintained.

The program that has been outlined consists of the following subjects:

- Admitting, discharging, transferring of patients.
- Bed making.
- Bed Baths.
- Supplies (Ordering, care of, etc.)
- Transferring patient from bed to litter or wheel-chair.
- Temperature, pulse, respirations.
- Specimen's - Proper collection (Importance).
- Enemata - cleansing, retention.
- Diets - proper serving of food - importance of well balanced diet.
- Work Roster - Organization of work.
- Oxygen Therapy - Proper handling of equipment - Precautions, etc.
- Ward Cleaning - dusting.
- Aseptic technic - Surgical carriage or cart
 - Dressings - Assisting Ward-Officer and Nurse
 - Cleaning cart - Restacking
- I. V. Fluids - Assisting the Ward-Officer.
- Injections - Penicillin (Under supervision of Nurse).
- Catheterizations - Assisting Ward-Officer.
- Isolation - Gown Technic
 - Proper Isolation technic
 - Care of equipment
 - Cleaning, disinfecting
 - Care of dishes (Method used at Fort Belvoir)
- Care of Dying Patient - Death of Patient
- Nursing Care of Fractures
- Casts - How applied..etc. - Care of Patient

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Balkan Frames - Skin Traction
Hot and Cold Applications - Hot water bottles
Ice caps
Wet dressings
Compresses
Sponges - Tepid, Alcohol

This outline is flexible and substitutions can be made if the need arises. Films on the above subject will be used to review and further impress upon the technician the importance of patient care. Time for return demonstration and practices has been included in the program.

Visual aids are always employed when possible, group discussion and student participation are encouraged. Demonstration of procedures and applicatory training are being employed throughout the program. This appears to be the most valuable method of teaching these subjects.

Observation on the wards by the instructors has been both enlightening and revealing as to the needs of the trainee in his actual ward situation. This evaluation is essential in determining the need for further practice and in the amplification or modification of the teaching plan. Our teaching program is not an elaborate one, but the obvious results are most gratifying.

Our hope is that this training program provides opportunities for growth and job satisfaction for our technicians, and that the stimulus thus provided will be an incentive to further their proficiency.

* * *

SHOCK RESEARCH TEAM

The Army Medical Service Graduate School is planning to send a Shock Research Team to Korea and Japan in a continuation of the study begun during the summer of 1951, by Dr. Simeone and his group. This team will be sent to study certain problems which the previous group felt demanded immediate investigation. The problems revolve around the response of the acutely injured man to trauma, with emphasis on shock, including hemorrhage, peritonitis, dehydration, and renal failure as major factors leading to the death of military personnel. These problems are so intimately associated that initially the same basic studies should be made on each patient. Working from the mobile Army Surgical Hospital, the team would have the opportunity to follow the injured soldier from the collecting station through the MASH to the Evacuation Hospital. During this time, basic observations such as those of hemodynamics, renal and hepatic function, total body water and the bacterial flora of the wound and blood stream would be made. After such base-line information is obtained, specialized studies would be selected for further investigation in the field and in the Zone of Interior. The Research Team will consist of one civilian scientist, six officers and six enlisted men. It is contemplated that the team will be in the theater approximately 5 months.

(The above is an extract from Surgeon General's Office, Weekend Letter No. 33, dated 16 November 1951)

* * *

ARMY MEDICAL PERSONNEL WIN OUTSTANDING NUMBER OF DECORATIONS IN KOREA

A preliminary survey reveals that over 2,800 decorations have already been awarded to Army Medical Service personnel for service in the Korean campaign, Major General George E. Armstrong, Army Surgeon General, recently announced.

The total includes a posthumous award of the Medal of Honor to Private Richard C. Wilson, aid man with the 187th Airborne Infantry Regiment; 9 Distinguished Service Crosses; 2 Distinguished Service Medals; 149 Silver Stars; 28 Legion of Merit awards; 2 Distinguished Flying Crosses; 11 Soldier's Medals; 1,369 Bronze Star Medals; 9 Air Medals; 126 Commendation Ribbons and 1,110 Purple Hearts.

(The above is from the Office of the Surgeon General, Technical Information Office, DA, Wash 25, DC)

PREVENTIVE MEDICINE

COMMENTS ON EPILEPSY, GRAND MAL

By
Colonel Donald B. Peterson, MC
Neuropsychiatric Consultant
Medical Section, GHQ, FEC

INTRODUCTION

This writing is necessitated by the fact that among Army personnel there are hundreds of individuals who are subject to convulsive seizures of the grand mal type. This constitutes a problem, not easy of solution, since by the nature of the condition, such persons are alternately fit for full duty or completely incapacitated.

Although epilepsy is common, and has been recognized for centuries; since the etiology is unknown, and since the pattern of convulsions is unique to each individual, there is considerable confusion and misconception in the medical and lay press, and in the minds of many physicians. It would be presumptuous to believe that these comments will resolve all confusion, but a restatement of the problem of epilepsy only with particular regard to the Army, may be of service.

That separation from the Service is not the entire solution to the problem is evidenced by AR 40-15 which states in part "Paroxysmal Convulsive Disorders....not controlled by medication are nonacceptable." The converse of this, of course, is that the controlled epileptic is acceptable and such person is enlisted and inducted into the Service. Further, for several years many known epileptics have been retained on general service under continuous standard anti-convulsive treatment, and where fraudulent entry into the Service occurred, a waiver of this fraud has been granted. This seems to be a matter not of general knowledge.

THE TYPES OF CONVULSIVE DISORDERS

For purposes of utilization of convulsive manpower, it is necessary to subdivide convulsive seizure disorders into functional groups so that evaluation of the patient with regard both to treatment and proper utilization may be made:

1. Organic Seizures
2. Syncopic Seizures
3. Psychogenic Seizures
4. Alcoholic Seizures
5. Epileptic Seizures

Organic seizures are an expression of organic brain disease or injury. Such patients together with syncopic patients constitute but a small proportion of seizure patients and do not enter into this discussion.

In almost all studies of large groups of convulsive seizures in both Army and Navy, it is found that about one-half of the patients initially thought to be epileptic are, in the final analysis, psychogenic. The psychogenic seizure patient is of importance to this discussion only because he occurs in such large proportion, and is most difficult to differentiate from the epileptic.

The alcoholic seizure patient is important in that the character of the seizures is identical with that of epilepsy, but the treatment of the two is quite divergent.

We are here concerned with the grand mal epileptic convulsive patient, not with petit mal, nor with psychomotor seizure. That a patient with grand mal seizures may, with careful observation, prove to have some psychomotor component is strictly academic and immaterial. What is material is whether or not the condition can be well and easily controlled with available and non-toxic drugs.

Thus, the alcoholic, psychogenic and epileptic patients are those with whom we are most concerned on the basis of utilization. The differentiation of these conditions is not too easy. It is frequently said that if the physician could only see the seizure, the differentiation would be simple. This is not true because the psychogenic often simulate the other two which are identical to observation, and further, most physicians see so few convulsive seizures that they have little opportunity to become acute observers.

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The alcoholic seizure is to be differentiated chiefly by history. These seizures occur only during the alcoholic hangover period. Careful history will reveal this. Any seizure occurring under other conditions is presumptively not alcoholic. Although not worked out statistically, in my experience, roughly 15% of true grand mal seizures are alcoholic. This condition is notable for the history mentioned, the almost invariably normal EEG, the fact that the seizures are not affected by dilantin and phenobarbital therapy and yield only to abstinence from alcohol. Parenthetically, it is believed that the inclusion of this condition into the diagnosis of idiopathic epilepsy is responsible for the belief, which to me seems erroneous, that alcohol is likely to precipitate a seizure in the epileptic patient. The diagnosis, ID, treatment and utilization or disposition of the alcoholic seizure patient are obvious from the above discussion.

The psychogenic seizure patient may be differentiated from the epileptic most easily and often, only by determining whether or not there was true amnesia of an organic absoluteness for the period of the seizure. In the psychogenic, the memory gap may be filled in by persuasive inquiry, hypnosis, or barbiturate interview. The necessity for this differentiation is obvious, both from the treatment and the utilization points of view, because here again are two similar appearing conditions which do not yield to the same treatment and which, if misdiagnosed and improperly treated vitiate all efforts at proper evaluation and utilization. The EEG is a fine differential aid with only about a 10% error.

THE NATURE OF GRAND MAL EPILEPSY

Only a sketchy discussion beamed at the relationship of the epileptic to the Army is contemplated. It should serve to round out knowledge, raise questions and rectify certain misconceptions.

1. Epilepsy is widely distributed, occurring in one out of about 200 of the general population.

2. Grand mal epileptic seizures occur generally during period of physical and emotional rest. They rarely occur when the individual is under pressure or active. Thus one battalion surgeon recently told me of three soldiers who presented convulsive seizures some days after running out of medication. Significantly, there were no convulsions until the unit came off the line into a rest area. This is standard, but is not a matter of general appreciation. Considering that one of each 200 persons one passes on the street and, very likely, the same ratio of automobile drivers, is epileptic, the fact that one seldom sees a convulsive seizure in people going about their daily business is significant of the fact that it is extremely rare for an epileptic, reasonably well controlled by medication, to have a convulsion during the time he is actively engaged in his daily duties. This fact cannot be stressed too much because there is a prevailing misconception to the contrary, which is responsible for much uniformed resistance to proper utilization of the epileptic.

3. Each epileptic on medication develops an individual, fairly rigid and predictable convulsive pattern. Thus, if the patient has had one seizure a year, it is not only fair, but reasonably accurate to prognosticate continuance of this pattern.

4. Once stabilized on medication, the administration of that medication must continue year in and year out. Altering the dosage timing, or drug may, of course, be done in order to achieve better control, but withdrawal of the drug will be followed by recurrence of seizure. A standard dosage of medication is 0.1 Gm Dilantin t.i.d. and 0.03 Gm Phenobarbital t.i.d. Variation from this schedule is often necessary and the dosage mentioned is to be regarded as a point of departure.

5. The Psychomotor epileptic individual of the epileptic fugue, clouded mental state type, in which gory crimes are committed, is rare. That individual is not to be confused with the grand mal epileptic who has a "psychomotor" component to his convulsion consisting, e.g. of lip smacking and masticatory movements. Similarly, mention of the word "psychomotor" in a report of EEG examination is not to be confused with a diagnosis of psychomotor epilepsy. The majority of EEG tracings in grand mal epilepsy may be described as psychomotor in type, but this is descriptive of the tracing, not of the patient's clinical seizure manifestations.

6. Much has been written on the "epileptic personality", indicating that there are certain aggressive, undesirable traits. There maybe some truth in such a concept in deteriorated, colonized epileptics, but in my experience with epileptics in the Army, quite the reverse is true. Very de-

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tailed, controlled clinical and psychological test evaluations have shown no such thing as a deviant personality in the Army epileptic. Of considerable importance is the fact that through ignorance the epileptic has experienced discrimination, and often reacts compensatorily, in a way, to prove he can do a job. Thus we frequently find controlled epileptics entering the Service fraudulently, conscientiously arranging for a continuous supply of their medication, and coming to our attention only when circumstance interferes with their source of supply. Further, two out of three give objective evidence of motivation for and desire to remain on duty. In psychogenic seizure this ratio is reversed. From this it is obvious that personality-wise, the epileptic has at least the minimum requirements to make a good soldier as found in the non-epileptic.

COMMENT

As stated above, although the nature of epilepsy does not change, yet our ideas regarding epilepsy are subject to much change. Many an unwarranted generalization has crept into the literature, due most likely to the confusing of alcoholic and psychogenic seizures with idiopathic grand mal epilepsy. It follows that our concepts regarding epilepsy need policing up; our diagnoses should be more accurate; and our dispositions should be more realistic from the utilization of manpower point of view.

The utilization of the epileptic requires that a clearcut evaluation be made so that only well controlled epileptics who are an overall asset to the Service are retained. Utilization also requires considerable reorientation of medical officers, no less than other officers of the using agency, so that on the one hand the unit surgeon accepts his responsibility to maintain the soldier on medication and on the other, classification, assignment, and commanding officers make proper assignment and use of the man, which for practical purposes permanently precludes only the driving of vehicles and working at dangerous heights.

Aside from the common sense fact that as far as possible all soldiers are to be used within the limits of their capabilities, there are other realistic factors to be considered. The Army does have quite a considerable pool of known and unknown epileptics; further known, controlled epileptics are being inducted into the Service legally since they are by regulation acceptable. Control of the seizures of the epileptic who fraudulently entered the service, and is dependent on a personal unofficial source of medication, is difficult to say the least, and inadequate. It follows that the intelligent handling and utilization of the epileptic requires some reorientation, accurate diagnosis and functional evaluation, and making the condition respectable. There surely is little point in losing a good soldier for the want of a little intelligent care and a moderate amount of dilantin and phenobarbital.

(The above is an article from The Surgeon's Circular Letter, Volume VI, Number 10, October 1951)

* * * * *

VITAMIN C IN FROZEN ORANGE JUICE

Frozen concentrated orange juice made from properly selected and prepared fruit is a dependable source of vitamin C and ... may be useful in the diets of persons of all ages, according to the Council on Foods and Nutrition of the American Medical Association.

In a statement published in the Journal of the American Medical Association, the council says: "It is reliably estimated that approximately 98 per cent of the vitamin C content of the fresh fruit may be retained in the frozen concentrated juice." The statement adds, however, that "danger of vitamin C loss is most likely to occur as a result of improper handling or storage in the home. For example, if, after reconstituting, juice is allowed to stand in open containers at room temperature, appreciable losses will occur. If the reconstituted juice is placed in the refrigerator at 40° F., vitamin C losses will be negligible. Ideally, the juice should be consumed as soon as possible after reconstituting to obtain maximum vitamin C values." If not used soon after mixing, the juice should be kept in covered containers.

(The above is from Connecticut State Department of Health, Weekly Health Bulletin, Vol. 33, No. 47)

PREVENTIVE MEDICINE

The following letter from the Surgeon General to the Commanding General, First Army, is reproduced in its entirety because of its importance. Wide dissemination is enjoined, as well as critical adherence.

DEPARTMENT OF THE ARMY
Office of the Surgeon General
Washington 25, D. C.

MEDCR 441 (1st Army Area) AA

5 November 1951

SUBJECT: Authorization for Use of Non-Approved Drugs and Treatments

TO: Commanding General,
First Army,
Governors Island, New York.
(ATTENTION: The Surgeon)

1. It is desired to call to your attention the fact that ACTH and Cortisone are not advocated by the Army Medical Service for use in the treatment of burns. This is not only because these are dangerously potent drugs whose exact field of usefulness has not been entirely delineated but also because they may decrease the rate of healing, sometimes favor a reduction in immunity to infection and seriously upset metabolic and electrolyte balances. Deaths and serious complications from their use have been reported in the civilian literature.

2. In this connection it is desired to point out further our concern over the increasing tendency to disregard the regulations (AR 40-507, AR 40-1705 and SGO Circular 162, 1951), which require specific approval of the Surgeon General if new drugs or treatments not approved by the National Research Council, the Council on Chemistry and Therapeutics of the American Medical Association or accepted on the Standard Supply Table, are to be used in Army hospitals. The widespread use of Curare by anesthetists is a case in point as this drug is still the subject of controversy and it has purposely not been added to the Standard Supply Table. It is not intended that funds for non-standard supplies be spent for items which do not fall within accepted policy for use.

3. It should be pointed out that there is no desire to prevent qualified medical officers from using new therapeutic agents but policies regarding new agents are adopted in consonance with the best national medical thought. The Army Medical Service should not be the first to adopt new measures before they are found acceptable nor should we be tardy in utilizing new developments. However, this falls within the scope of organized research and development and should not be the uncontrolled function of medical officers in general. It is realized that acceptance by recognized agencies prior to adoption for Army use will slow availability of new agents but rarely are these of emergency life-saving value which would warrant their adoption before proper testing.

4. It is urged that these matters be brought to the attention of all key Army Medical officers of your command to the end that specific permission for the use of non-approved drugs and treatments be obtained prior to their use in Army hospitals.

/s/ GEORGE E ARMSTRONG
Major General
The Surgeon General

PREVENTIVE MEDICINE

EPIDEMIC HEMORRHAGIC FEVER

Abstracts from report by Capt. Ralph Takami, MC and Tech. Info. Off, SGO

Epidemic hemorrhagic fever is an acute infectious disease of virus etiology. The specific causative agent was shown to be a filterable virus capable of passing chamberland candles L2, L3, L5, L9 and Seitz EK filters. It is said to be transmitted by the mite, *lawlaps Jettmari Vitzthum*. The host of the mite and probable reservoir of the disease is the field rodent *apodemus agrarius*. Rats, squirrels and horses also are suspected as carriers of the mites.

The fever is believed especially prevalent in areas along river banks and in swampy marshlands where the grass grows high and is unattended. It has been variously known as Songo Fever, Kokka Disease, Korin Fever, Nidoko Disease -- names referable to districts in the Orient. In 1942 it was officially recognized as a disease entity and designated "Epidemic Hemorrhagic Fever" by the Medical Department, Japanese Army.

The incubation period of epidemic hemorrhagic fever may be as long as 21 days.

The initial signs and symptoms of Epidemic Hemorrhagic Fever are chills, fever (102 degrees to 104 degrees Fahrenheit), headache, and vomiting. Fever usually lasts 4 to 5 days. Physical signs include petechia in skin, sub-conjunctival injections and hemorrhage, hiccoughs, albuminuria, hematuria, hemoptysis, hematemesis and melena, blood pressure reduced as low as 70, pulse increase as high as 120. Laboratory findings include red blood cell rise to 8 million, leukemoid leukocytosis of 30 to 70 thousand, reduced blood thrombin. Mortality rate has been from 11 to 15 percent. Antibiotics and chemotherapy ineffective. Palliative treatment apparently reduces mortality. Use of Vitamins K and C are suggested. No vaccine has yet been discovered.

In general prognosis is poor if there is bradycardia and hypotension at the beginning of the eruptive period (3 days). Persistent hiccoughing is also a bad prognostic sign and cases develop frank pulmonary hemorrhage or severe cerebral symptoms nearly always have a fatal termination.

Preventive measures include good field sanitation (careful choice of camp sites), and individual protective measures such as insect repellants.

* * * * *

COMMON PITFALLS IN THE X-RAY DIAGNOSIS OF TUBERCULOSIS

Excerpt from an article by Dr. Jos. D. Wassersug "The New England Journal of Medicine"

1. Failure to correlate physical findings with x-ray examination.
2. Failure to compare films of similar densities often results in the illusion of a lesion's increasing or decreasing in size.
3. Failure to place adequate emphasis on history.
4. Reliance on an inadequate x-ray examination.
5. Comparison of x-rays too far apart in time lead to erroneous conclusions.
6. Reliance on posteroanterior films without special spot examinations may be extremely misleading.
7. Sputum examinations must be made even when the x-ray films show no change and even when special films reveal no evidence of further disease.
8. Basal disease may be tuberculous, particularly if it occurs in the young adult with history of pleurisy within five years prior to the "pneumonia".
9. Pleurisy with effusion of a young adult is often a forerunner of pulmonary tuberculosis. Patients with pleural effusions should not be dismissed from observation for at least five years after their effusion.
10. X-ray films are worthless if they are not interpreted by competent physicans.

VETERINARY SERVICE

EXTERMINATE RODENTS WITH DRY ICE

Food plants face a tough problem in rodent extermination. Chemicals which are permissible in other industrial plants are prohibited in virtually all food plants. Trapping rodents is one acceptable, if tedious method. The best control method is good housekeeping and proper plant construction.

A food plant may have an excellent sanitary policy within its walls, but fall short in disposing of trash. Trash of any sort should be burned daily and buried or hauled away. Wherever possible, walls and floors should be constructed of concrete.

However, for older plants where wood is the predominant structural element, or in inexpensively constructed storage and supply facilities, a rodent control program announced in the October issue of "Refrigeration Research Foundation Information Bulletin," might prove very helpful. It is realized that within the meat industry this program would need approval of the MID (Meat Inspection Division, Bureau of Animal Industry, Department of Agriculture) inspector at the plant as set forth in MID Memorandum 52.

Dry ice is the medium used to force rats out of their burrows and suffocate them. Used in a west coast food plant, this method was found to be effective, inexpensive and, with proper supervision, safe.

In any meat plant, the area to be treated would first be emptied of all products and then sealed off. Sealing should be sufficient to prevent mass air movement and can usually be accomplished by closing all doors, windows and air ducting. Next, the area should be given an initial charge of dry ice sufficient to give off a 20 per cent CO₂ concentration. A leading dry ice manufacturer advises that one pound of dry ice will, on sublimation (changing from solid to gaseous form), saturate 8.5 cu. ft. of air at atmospheric pressure. To calculate the desired lethal saturation requirements for any area, the cubic footage must first be figured, divided by one-fifth, and then this figure divided by 8.5 for the dry ice poundage needs.

To hasten sublimation, the dry ice should be broken into chunks the size of marbles. The rate of sublimation will depend upon room temperature, being hastened by higher temperatures. However, it is not necessary to heat any refrigerated areas as the sublimation temperature of dry ice is minus 108° F. If rooms have unit coolers, it is recommended that the units be allowed to operate during the sublimation period. The amount of dry ice vapors absorbed by the brine would be negligible and the air circulation speeds sublimation.

A fan can be directed at the dry ice particles in dry storage rooms. The small pieces of dry ice will sublimate in about ten minutes on the average. To be effective, the saturation should be maintained for at least 12 minutes. The amount of CO₂ concentration that is lost will have to be estimated in terms of air leakage. An exact way to calculate the air saturation with sublimated dry ice vapors is by using a CO₂ Burette meter, available from any reputable scientific apparatus house.

Death comes to the rodents by suffocation. As the CO₂ is heavier than air it filters down into the burrows and forces the rodents to the surface. There is no danger of post mortem food contamination as the rodents reportedly come into the clear and can be easily removed. Further, the saturation of dry ice gas leaves no residual effect to the building or equipment within the building. Except to change the air for the safety of employees, no cleanup operations are necessary.

A word of caution about this method of rodent extermination. A carbon dioxide-saturated atmosphere from the dry ice can kill humans. A 6 per cent concentration will cause hard breathing; 10 per cent, severe distress; 15 per cent, semi-consciousness, and 25 per cent, death. In working in a CO₂ filled room, it should be remembered that the ordinary gas mask offers no protection. A regular oxygen mask with an oxygen cannister must be used for safety.

With common sense supervision, however, dry ice presents no danger. Quickly broken in a grinder of one kind or another, or with a hammer, small pieces of dry ice can be rapidly spread in the saturation area. Employees can leave the room and seal the door before the gas has any toxic effect on them.

VETERINARY SERVICE

CAUTIONS CARE IN ANTIRABIC VACCINE USE

T. F. Sellers, M. D., director of the Georgia Department of Public Health, warned that antirabic vaccine is not harmless and that there is considerable danger of inducing treatment paralysis.

During the past few years mortality from rabies has declined but antirabic sensitization deaths and serious complications have increased to the point where physicians must now realize that antirabic vaccine should not be administered indiscriminately, he stated.

Two concepts have emerged from the research of the past few years. First, rabies is communicable only by direct bite into the flesh deep enough to touch nerve tissue and, second, antirabic vaccine prepared from brain tissue, if repeatedly injected over a long period of time, may induce specific brain tissue sensitization, sometimes causing treatment paralysis, a serious and often fatal complication, Dr. Sellers reported.

Standards for considering the animal as potentially infectious were outlined by Dr. Sellers as follows:

1. The animal is clinically rabid, even though post-mortem brain examination fails to reveal Negri bodies.
2. Clinical behavior before death was not rabid, but brain shows Negri bodies.
3. If the animal that bites without provocation and is immediately killed should be suspected even if laboratory findings are negative.

Antirabic treatment is indicated, Dr. Sellers stated when:

1. Wounds have penetrated the skin.
2. Wounds were inflicted through clothing torn by the animal's teeth.
3. It is suspected that the saliva contacted fresh, open, or raw preexistent abrasions.
4. When the exposed person is too young to give reliable testimony.

Antirabic treatment is contraindicated, he said:

1. When there is no broken skin anywhere on the body, including face or mouth.
2. If previous wounds are known to be over 24-hours old or are covered with an unbroken scab.
3. If the tooth wounds were made through untornd clothing - such wounds are usually bruises.
4. If exposure is limited to handling only the dog or objects contaminated with the saliva, or to drinking the milk of rabid cows or goats.
5. If the wounds were inflicted not less than 7 days prior to the detection of visible signs of the disease.
6. If the animal remains normal for as long as 7 days after inflicting the wounds.

Reimmunization should be avoided for borderline exposures regardless of the time elapsed since the last treatment, Dr. Sellers stated. Retreatment should be limited in any case to a short booster series of five or six injections.

Extracted from Public Health Reports, Vol. 66, No. 35, August 31, 1951.

GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations, exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 14)

The non-effective rate* decreased from the October rate of 16.62 to 15.95 for the month of November. Days lost as a result of disease and injury totaled 12,677 during the four week period ending 28 November 1951.

*Non-Effective Rate -- $\frac{\text{Total Days lost} \times 1,000}{\text{No. of Days Average Daily in Period} \times \text{Strength}}$

Non-Effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate** for disease and injury in November was 338.5, compared to 404.6 during October. Total admissions for disease and injury in November was 763. Of this number 680 admissions were for disease and 83 injuries. Fort Myer reported the highest admission rate, and US Army Dispensary, The Pentagon reported the lowest rate during the current month.

**Admission Rates -- $\frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

November's rate for disease cases is 301.6 for 680 cases. Fort Belvoir reported the highest admission rate, and US Army Dispensary, The Pentagon reported the lowest rate for disease cases.

An injury admission rate of 36.8 per 1,000 per annum for November was reported. This was a decrease from the October rate of 56.2. Fort Belvoir reported the highest rate and US Army Dispensary, The Pentagon reported the lowest rate for injuries.

There were 3 deaths reported during the four week period ending 28 November 1951, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases increased in incidence during the month of November 1951. The rate for the present month is 112.2 compared to the October rate of 108.1. Fort Myer reported the highest rate, and All Others reported the lowest rate. Admission rates for pneumonia (all types) increased during the November report period. The rate being 7.5 compared with the October rate of 5.8. There were no cases of scarlet fever reported through the month of November.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, and hepatitis during the four week period ending 28 November 1951.

Pertinent statistical tables may be found on pages 15 and 19.

PREVENTIVE MEDICINE

GENERAL DATA
4-Week Period Ending 28 November 1951
(Data from DD Forms 442)

STATION	MEAN STANGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disase		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Virginia	17933	15828	2105	433	314.74	368	267.49	65	47.25	15.69	2
Fort McNair, Wash, DC	881	811	70	29	429.07	28	414.27	1	14.80	7.34	0
Fort Myer, Virginia	3893	3737	156	154	515.64	147	492.20	7	23.44	11.27	1
US Army Dispensary The Pentagon	3972	3954	18	82	269.10	78	255.97	4	13.13	23.04	0
All Others	2703	2697	6	65	313.36	59	284.52	6	28.93	10.02	0
Total - Military Dist. of Washington	29382	27027	2355	763	338.50	680	301.67	83	36.82	15.95	3
AMC - Med. Detach. (Duty Pers)	1652	1517	135	74	583.90	64	505.00	10	78.90	24.40	0

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
4-Week Period Ending 28 November 1951
(Data from DD Form 442)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir, Va.	87.22	7.27	4.36	-	.73	.73	-	1.45	-	2.91	-	3.63
Fort McNair, Wash, DC	162.75	14.80	-	-	-	-	-	-	-	-	14.80	-
Fort Myer, Virginia	220.99	13.39	3.35	-	-	-	-	-	-	-	-	-
US Army Dispensary The Pentagon	137.83	3.28	-	-	-	3.28	-	-	-	--	-	3.28
All Others	67.51	4.82	-	9.64	-	-	-	-	-	-	-	4.82
Total-Military District of Washington	112.24	7.54	3.11	.89	.44	.89	-	.89	-	1.77	.44	3.11
AMC-Medical Detachment (Duty Personnel)	71.00	-	-	47.30	-	-	-	-	-	-	-	-

* * *

FIELD TESTS WITH MOSQUITO AND SAND FLY REPELLENTS IN ALASKA

In field tests 10 repellents were used as 25% solns. on the skin; 6 were effective for 113 min. or more against *Aedes flavescens*, and 7 for 34 min. or more against *A. excrucians*, *A. communis*, and *A. pionips*. Propyl N. N-diethylsuccinamate was the most effective against *A. flavescens*, whereas this material and dimethyl phthalate, which were about equally effective, afforded better protection than the other materials against the mixed populating of *Aedes*. Cream prepn's, containing 20% of the 10 repellents were slightly less effective than 25% concns. of the repellents applied as liquids. In tests with 35 materials applied to fabrics, 10 were effective against mosquitoes after 4 rinsing and 16 hours of wear. Hexylmandelate, which was the most effective, withstood 13 rinsings and 40 hrs. of wear. Repellents applied to mesh face masks failed to give adequate protection from sand flies (*Culicoides*) -- K. H. Applewhite & Carroll N. Smith, Jour. Econ. Ent., 43, 353-357 (1950). (BA Apr. 1951)

PREVENTIVE MEDICINE

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VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington, decreased during the November report period.

The rate for November 1951, was 11.09, a decrease from the October rate of 18.51. A total of 25 cases were reported for the four week period ending 28 November 1951. Of this total 23 were reported by Fort Belvoir, 1 case for Fort McNair and 1 case for Fort Myer.

During the report period, white personnel incurred 5 of the report number of cases, with a rate of 2.41 and 20 were incurred by Negro personnel with a resulting rate of 110.70 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (November) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 16 and 17.

NEW VENEREAL DISEASE CASES - EXCL EPTS - SEPTEMBER, OCTOBER AND NOVEMBER 1951

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	SEPTEMBER 1951	OCTOBER 1951	NOVEMBER 1951	NOVEMBER 1951
Fort Belvoir	18.09	25.43	16.72	1.282
Fort McNair	-	57.68	14.80	1.135
Fort Myer	23.26	10.86	3.35	.256
US Army Dispensary, Pentagon	-	-	-	-
All Others	4.47	-	-	-
Total - Military District of Washington	14.37	18.51	11.09	.850
Army Medical Center - Medical and Holding Detachments	12.27	13.07	28.21	2.163
Total - Dept/Army Units Military Dist/Wash	14.06	18.02	12.79	.981

* * * SOME EFFICIENCY REPORTS ELIMINATED

In a recent cable to all major commanders, and pending changes to AR 600-185, it was directed that all semi-annual efficiency reports now required of officers from warrant through major be eliminated in favor of only the annual reports.

A similar move was taken to eliminate efficiency reports for top three-graders of the Regular Army.

These moves are not explained in the cable, but they will in effect save untold numbers of man-hours now consumed in preparing and processing such reports. A considerable quantity of paper will also be saved--at least one sheet for each officer and enlisted man concerned.

(The above is from "Report to the Army", November 1951)

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CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY

MDW RATE PER 1000 TROOPS PER YEAR

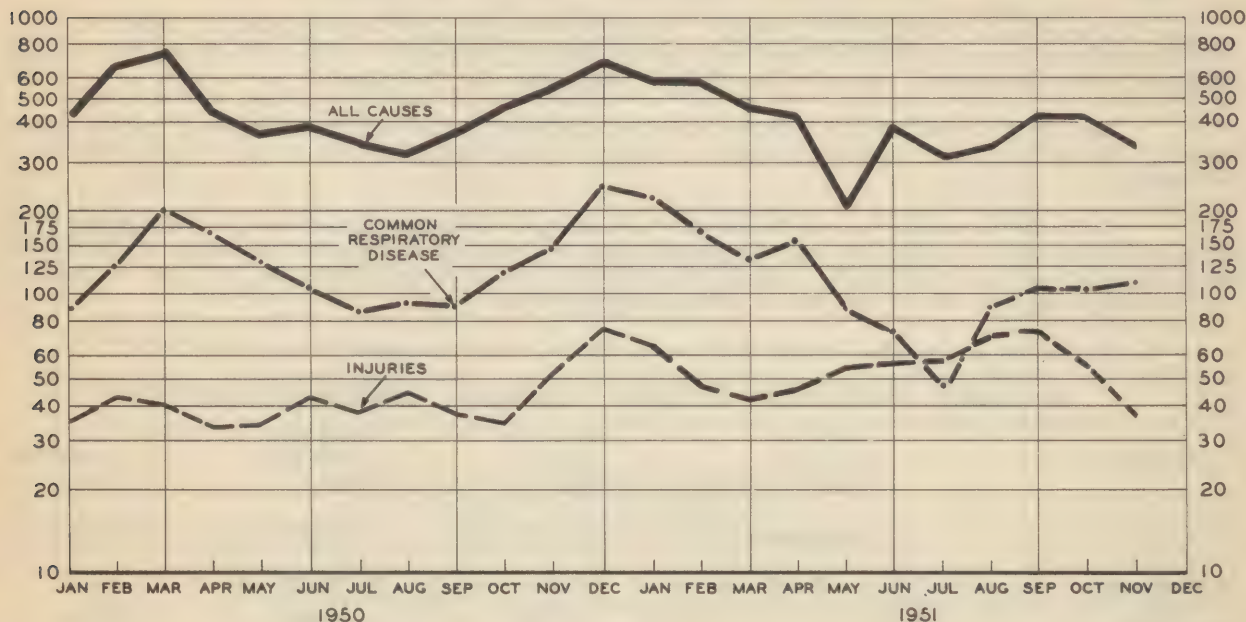
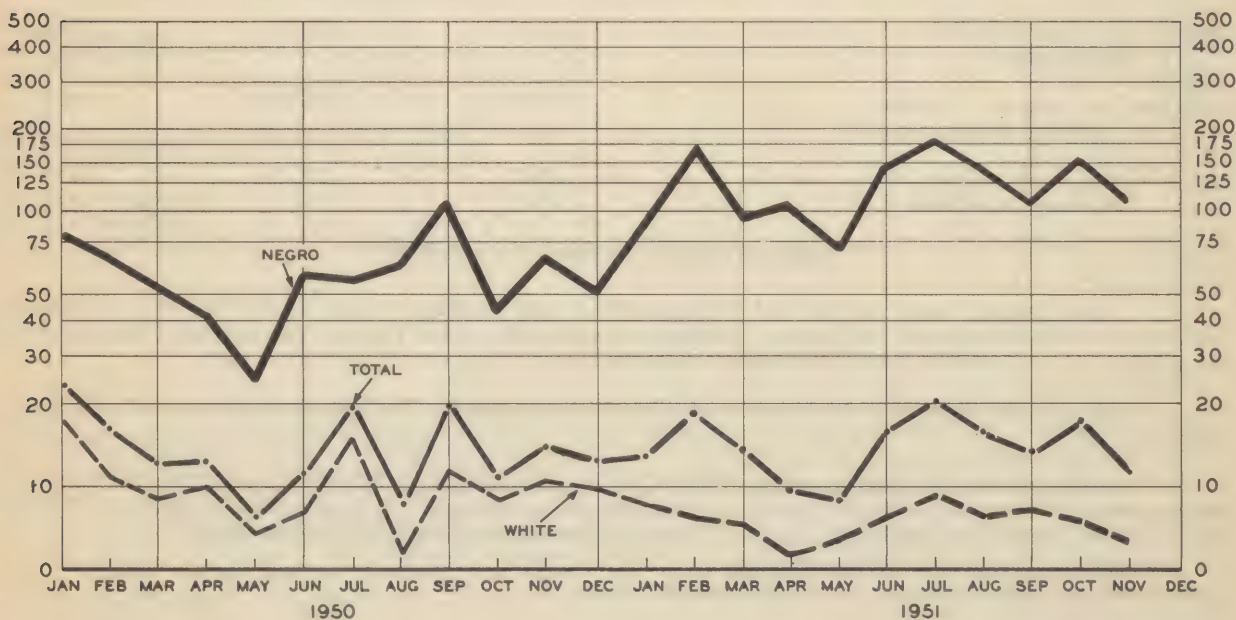


CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER

RATES PER 1000 TROOPS PER YEAR

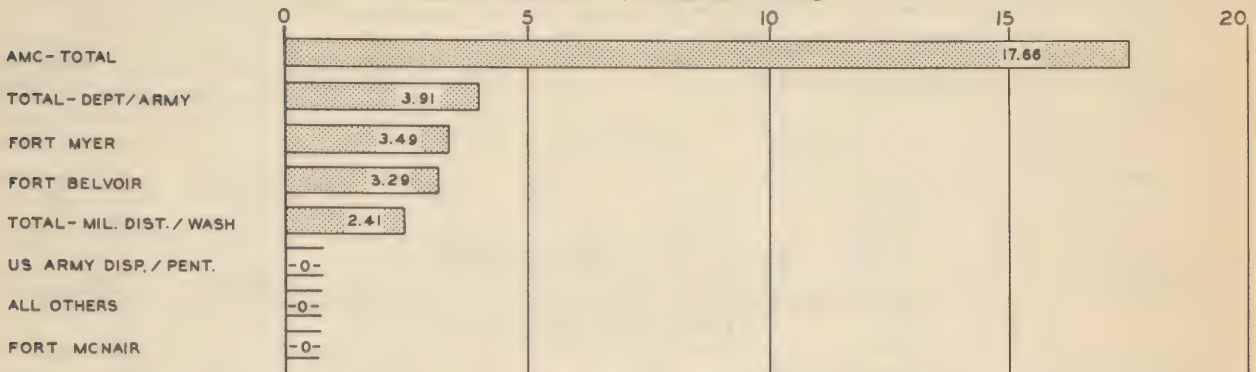
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



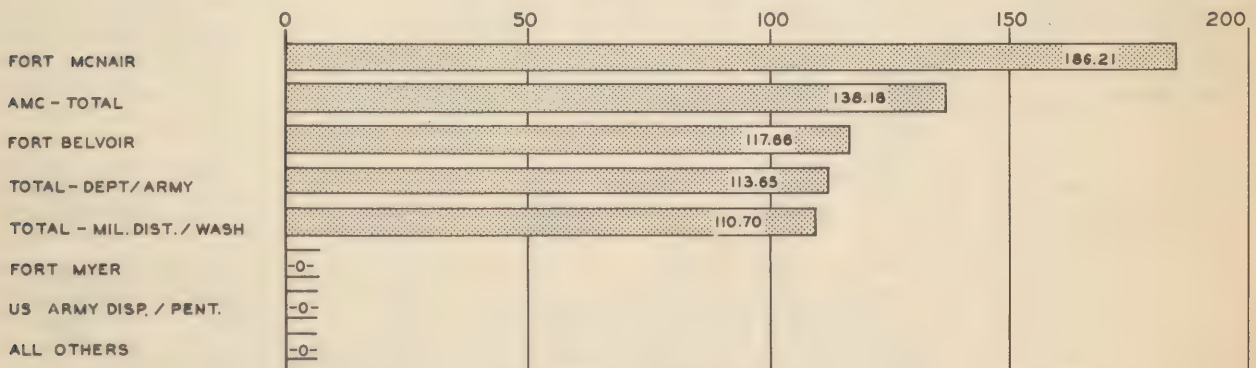
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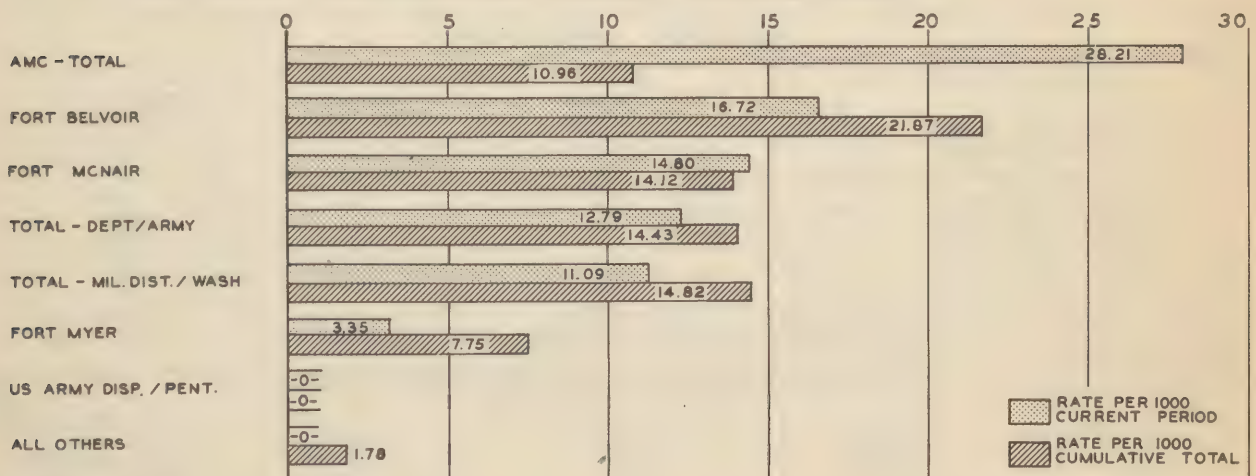
VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 28 NOV 1951 WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 28 NOV 1951 NEGRO PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATES PER 1000 PER YEAR FOUR WEEK & CUMULATIVE TOTALS ENDING 28 NOV 1951 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



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PREVENTIVE MEDICINE**CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT**

For the Four Week Period Ending 28 November 1951

(Data from DD Forms 442) (Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rate Per 1000 Troops per Annum	Cases per 1,000 Troops
Fort Belvoir	W	15828	2	2	0	4	3.29	.252
	N	2105	2	16	1	19	117.66	9.026
	T	17933	4	18	1	23	16.72	1.282
Fort McNair	W	811	0	0	0	0	-	-
	N	70	0	1	0	1	186.21	14.285
	T	881	0	1	0	1	14.80	1.135
Fort Myer	W	3737	0	0	1	1	3.49	.267
	N	156	0	0	0	0	-	-
	T	3893	0	0	1	1	3.35	.256
US Army Dispensary The Pentagon	W	3954	0	0	0	0	-	-
	N	18	0	0	0	0	-	-
	T	3972	0	0	0	0	-	-
All Others	W	2697	0	0	0	0	-	-
	N	6	0	0	0	0	-	-
	T	2703	0	0	0	0	-	-
Total-Military District of Washington	W	27027	2	2	1	5	2.41	.185
	N	2355	2	17	1	20	110.70	8.492
	T	29382	4	19	2	25	11.09	.850
Army Medical Center	W	2952	4	0	0	4	17.66	1.355
	N	283	1	2	0	3	138.18	10.600
	T	3235	5	2	0	7	28.21	2.163
Total-Dept/Army Units	W	29979	6	3	0	9	3.91	.300
	N	2638	3	19	1	23	113.65	8.718
	T	32617	9	22	1	32	12.79	.981

VENEREAL DISEASE RATES*

(All Army Troops)

	SEPTEMBER 1951	OCTOBER 1951	NOVEMBER 1951
First Army Area	42	30	29
Second Army Area	28	26	27
Military District of Washington	14	18	13
Third Army Area	26	28	27
Fourth Army Area	38	33	36
Fifth Army Area	29	25	26
Sixth Army Area	38	42	37
TOTAL United States	32	30	29

*Compiled in the Office of the Surgeon General and Includes US Army Hospitals.

DENTAL SERVICE

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DENTAL SERVICE - FOUR WEEK PERIOD ENDING 28 NOVEMBER 1951

STATION	Total Dentists		Sittings	Fillings	Bridges	Crowns	Dentures	Calculus Removed	Teeth Removed	Roentgenograms	Examinations
	Officer	Civilian									
Fort Belvoir	32	0	8019	4299	14	13	174	385	1455	2869	385
Fort McNair	2	0	450	342	1	1	12	25	0	475	106
Fort Myer	5	1	1664	495	1	0	17	173	153	479	602
US Army, Dispensary, Pent.	8	0	1518	644	3	6	21	99	106	1196	2113
All Others	4	0	1133	592	2	6	21	61	130	246	469
Total - MDW	51	1	12784	6372	21	26	245	743	1844	5265	7706

VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED NOVEMBER 1951
(Data obtained from WD AGO Forms 8-134)

STATION	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		80,405	152,248		236,655		67,355	536,663
Fort Belvoir, Virginia		672,149	421,851		985,359	177,695	523,386	2,780,440
Alexandria Field Buying Office		587,400	118,808	756,729			87,100	1,550,037
Fort Myer, Virginia		151,782	203,305		308,953	5,289	127,966	797,295
Cameron Station, Virginia		165,974	197,275	912	348,084	7,463	120,436	840,144
MDW Veterinary Detachment	1,025,775							1,025,775
The Pentagon						309,677		309,677
Army Medical Center		236,229	173,200		388,148	11,985	93,038	902,600
TOTAL	1,025,775	1,893,687	757,641	757,641	2,267,199	512,109	1,019,281	8,742,631

REJECTIONS:

Not type class or grade

Fort Myer, Va.

MDW Vet. Detach.

Alexandria Field Buy. Off.

7,365

750

110

110

7,365

750

Insanitary or Unsound

MDW Vet. Detach.

Alexandria Field Buy. Off.

12,809

6

12,809

6

TOTAL:

20,174

750

6

110

21,040

*Class 3 - Prior to Purchase

*Class 4 - On delivery at Purchase

*Class 5 - Army Receipt except Purchase

*Class 6 - Prior to Shipment

*Class 7 - At Issue

*Class 8 - Purchase by Post Exchange, Clubs

Messes or Post Restaurants

*Class 9 - Storage

OUTPATIENT SERVICE

OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the four week period ending 28 November 1951:

ARMY:

Number of Outpatients. 16203

Number of Treatments 20160

NUMBER OF COMPLETE PHYSICAL EXAMINATION CONDUCTED.

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED

NON-ARMY:

Number of Outpatients. 16391

Number of Treatments 18416

NUMBER OF COMPLETE PHYSICAL EXAMINATION CONDUCTED. 3197

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 15511

HOSPITAL MESS ADMINISTRATION

HOSPITAL MESS ADMINISTRATION

STATION	AUGUST 1951	SEPTEMBER 1951	OCTOBER 1951	NOVEMBER 1951
Fort Belvoir				
Income per Ration	\$1.3455	\$1.353	\$1.3232	\$1.3187
Expense per Ration	1.2556	1.333	1.3335	1.2668
Gain or Loss	+.0900	+.020	-.0103	+.0519

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DIFFICULTIES IN THE MANAGEMENT OF CONGESTIVE HEART FAILURE

By
Charles E. Kossmann

The treatment of congestive heart failure is often regarded as a routine procedure. The truth is that management of the syndrome is a highly individualized matter which depends, among other things, on the patient himself, the particular cardiac disease from which he suffers, and the special and variable circumstances which precipitated the failure. The methods used in combating it are, to be sure, quite standard—rest, digitalis, diuretics and restriction of sodium in the diet. But to use these methods in a fixed way for all patients with heart failure may give an avoidably poor therapeutic result.

"Rest" is subject to many interpretations. To some physicians it means continuation of all moderate activity with perhaps an additional hour or two in bed at night or at midday; to others it means complete rest in bed with almost no movement of the body whatsoever. Further, a certain amount of confusion has resulted from several articles on the abuse of rest in the treatment of heart failure which have been misinterpreted as meaning that rest is a harmful thing to be avoided at all costs.

There is no alternative but to put the patient with severe congestive heart failure at rest, usually in bed. This is done in order to achieve principally two things: to reduce the metabolic needs of the body to a minimum and to augment the flow of blood through the kidneys to a maximum. During the first 24 hours in bed and sometimes for longer periods—such patients may occasionally get worse, with an exaggeration of their symptoms due to the mobilization of fluid from the extracellular space of the lower parts of the body. They must be given the advantage of gravity to keep this fluid away from the critical area, the lungs. This can be accomplished by slight elevation of the head of the bed with the aid of blocks, as well as with the back-up position of the Gatch bed. In extreme circumstances it may be necessary for the patient to remain in a chair with the extremities well below the general body level, and rarely one sees a patient who, during paroxysms of dyspnea, insists on standing, with the trunk bent forward. In general, patients in chronic failure requiring the "chair treatment" have far advanced disease and not too much can be accomplished for them therapeutically.

The obvious hazards of rest in bed—namely, thromboembolism, negative calcium and nitrogen balance, massive collapse of the lung, constipation, urinary retention and the like—may be overcome in large part by good nursing care with frequent passive exercises and massage to the lower extremities, deep breathing exercises when the condition of the patient permits, and anticoagulants if facilities exist for their controlled administration.

Decisions as to the amount of absolute bed rest, the use of a commode or nearby bathroom instead of a bedpan, and engagement in other activity require judgment and frequently simple trial and error. If the act of getting on a commode or taking a few steps to a bathroom precipitates pulmonary edema, clearly these activities must be eliminated.

Some details of rest for the very sick patient are often overlooked. For example, an overzealous family or wife can cause untold mental and physical wear on patient with repeated questioning about the details of his illness including its probable cost. Under such circumstances all visitors should be prohibited for a period as long as the physician regards as necessary. Many patients, especially executives, demand that a telephone be near the bedside. Long business conversations can often do a great deal of harm. The telephone must be removed or shut off, at least during the first few days of the illness.

One of the latest additions, at least to the investigator's armamentarium, in the treatment of congestive heart failure is the cation exchange resin. These resins are already available for use by the physician, but it would seem unwise to give them to a patient for any length of time unless facilities are available for the repeated study of the plasma electrolytes. These preparations are taken by mouth and act by absorbing cations such as sodium, potassium, calcium and magnesium. With the aid of such drugs it is possible for the patient to take a larger amount of sodium in his diet than ordinarily would be the case. The disadvantages of the preparations are that they are bulky, very often cause nausea and other gastrointestinal disturbances, and as noted above, will remove cations other than sodium.

The above article is from "Postgraduate Medicine", Vol. 10, No. 5, November 1951.

TEMP. TECHNIQUE

1.

WIDE

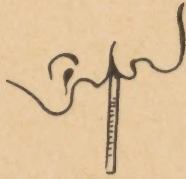
THERMOMETER. TEMPERATURE



2.

TAKE

TEMPERATURE



3.

PLACE IN

GREEN SOAP

5 MINUTES.

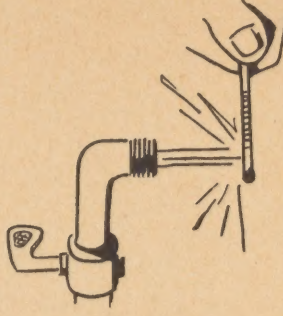


4.

RINSE IN

COLD RUNNING

WATER.



5.

PLACE IN

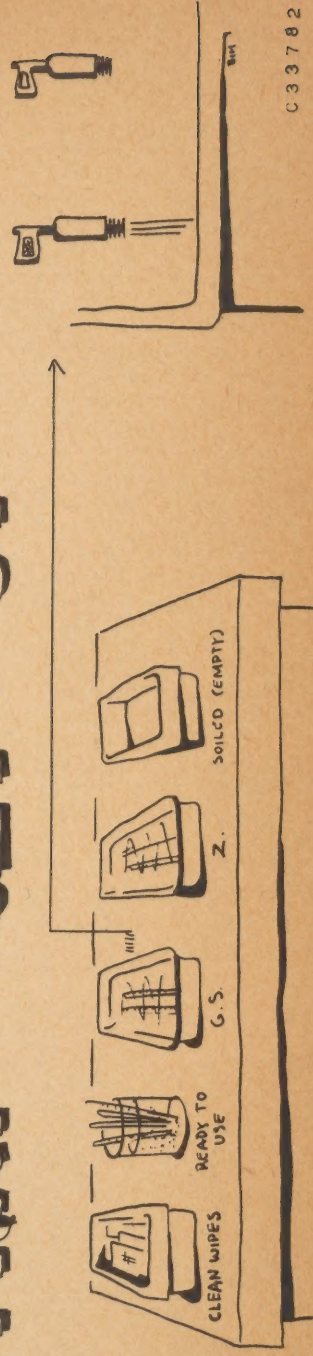
ZEPHIRAN

AT LEAST

3 MINUTES.



TRAY SET - UP



RESTRICTED

Security Information

RESTRICTED

Security Information